

AMENDED IN SENATE AUGUST 29, 2016
AMENDED IN SENATE AUGUST 19, 2016
AMENDED IN ASSEMBLY APRIL 19, 2016
AMENDED IN ASSEMBLY MARCH 29, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2503

Introduced by Assembly Member Obernolte

February 19, 2016

An act to amend Section 4610 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 2503, as amended, Obernolte. Workers' compensation: utilization review.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law requires every employer, for purposes of workers' compensation, to establish a utilization review process to prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, as provided. Existing law requires prospective or concurrent decisions to be made in a timely fashion that ~~are~~ *is* appropriate for the nature of the employee's condition. Existing law also requires that decisions to approve, modify, delay, or deny requests

by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees be communicated to the requesting physician within 24 hours of the decision.

This bill would require a physician providing treatment to an injured worker to send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. The bill would also make technical changes.

This bill would incorporate changes to Section 4610 of the Labor Code proposed by this bill and SB 1160, to be operative if both bills are enacted and this bill is enacted after SB 1160.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 4610 of the Labor Code is amended to
2 read:
3 4610. (a) For purposes of this section, “utilization review”
4 means utilization review or utilization management functions that
5 prospectively, retrospectively, or concurrently review and approve,
6 modify, delay, or deny, based in whole or in part on medical
7 necessity to cure and relieve, treatment recommendations by
8 physicians, as defined in Section 3209.3, prior to, retrospectively,
9 or concurrent with the provision of medical treatment services
10 pursuant to Section 4600.
11 (b) Each employer shall establish a utilization review process
12 in compliance with this section, either directly or through its insurer
13 or an entity with which an employer or insurer contracts for these
14 services.
15 (c) Each utilization review process shall be governed by written
16 policies and procedures. These policies and procedures shall ensure
17 that decisions based on the medical necessity to cure and relieve
18 of proposed medical treatment services are consistent with the
19 schedule for medical treatment utilization adopted pursuant to
20 Section 5307.27. These policies and procedures, and a description
21 of the utilization process, shall be filed with the administrative
22 director and shall be disclosed by the employer to employees,
23 physicians, and the public upon request.

(d) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, that employer, insurer, or other entity shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) A person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, if these services are within the scope of the physician's practice, requested by the physician, shall not modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the

1 specific procedures or conditions requested. An employer may
2 charge members of the public reasonable copying and postage
3 expenses related to disclosing criteria or guidelines pursuant to
4 this paragraph. Criteria or guidelines may also be made available
5 through electronic means. A charge shall not be required for an
6 employee whose physician's request for medical treatment services
7 is under review.

8 (g) In determining whether to approve, modify, delay, or deny
9 requests by physicians prior to, retrospectively, or concurrent with
10 the provisions of medical treatment services to employees all of
11 the following requirements shall be met:

12 (1) Prospective or concurrent decisions shall be made in a timely
13 fashion that ~~are~~ *is* appropriate for the nature of the employee's
14 condition, not to exceed five working days from the receipt of the
15 information reasonably necessary to make the determination, but
16 in no event more than 14 days from the date of the medical
17 treatment recommendation by the physician. In cases where the
18 review is retrospective, a decision resulting in denial of all or part
19 of the medical treatment service shall be communicated to the
20 individual who received services, or to the individual's designee,
21 within 30 days of receipt of the information that is reasonably
22 necessary to make this determination. If payment for a medical
23 treatment service is made within the time prescribed by Section
24 4603.2, a retrospective decision to approve the service need not
25 otherwise be communicated.

26 (2) If the employee's condition is one in which the employee
27 faces an imminent and serious threat to his or her health, including,
28 but not limited to, the potential loss of life, limb, or other major
29 bodily function, or the normal timeframe for the decisionmaking
30 process, as described in paragraph (1), would be detrimental to the
31 employee's life or health or could jeopardize the employee's ability
32 to regain maximum function, decisions to approve, modify, delay,
33 or deny requests by physicians prior to, or concurrent with, the
34 provision of medical treatment services to employees shall be made
35 in a timely fashion that is appropriate for the nature of the
36 employee's condition, but not to exceed 72 hours after the receipt
37 of the information reasonably necessary to make the determination.

38 (3) (A) Decisions to approve, modify, delay, or deny requests
39 by physicians for authorization prior to, or concurrent with, the
40 provision of medical treatment services to employees shall be

1 communicated to the requesting physician within 24 hours of the
2 decision. Decisions resulting in modification, delay, or denial of
3 all or part of the requested health care service shall be
4 communicated to physicians initially by telephone or facsimile,
5 and to the physician and employee in writing within 24 hours for
6 concurrent review, or within two business days of the decision for
7 prospective review, as prescribed by the administrative director.
8 If the request is not approved in full, disputes shall be resolved in
9 accordance with Section 4610.5, if applicable, or otherwise in
10 accordance with Section 4062.

11 (B) In the case of concurrent review, medical care shall not be
12 discontinued until the employee's physician has been notified of
13 the decision and a care plan has been agreed upon by the physician
14 that is appropriate for the medical needs of the employee. Medical
15 care provided during a concurrent review shall be care that is
16 medically necessary to cure and relieve, and an insurer or
17 self-insured employer shall only be liable for those services
18 determined medically necessary to cure and relieve. If the insurer
19 or self-insured employer disputes whether or not one or more
20 services offered concurrently with a utilization review were
21 medically necessary to cure and relieve, the dispute shall be
22 resolved pursuant to Section 4610.5, if applicable, or otherwise
23 pursuant to Section 4062. A compromise between the parties that
24 an insurer or self-insured employer believes may result in payment
25 for services that were not medically necessary to cure and relieve
26 shall be reported by the insurer or the self-insured employer to the
27 licensing board of the provider or providers who received the
28 payments, in a manner set forth by the respective board and in a
29 way that minimizes reporting costs both to the board and to the
30 insurer or self-insured employer, for evaluation as to possible
31 violations of the statutes governing appropriate professional
32 practices. Fees shall not be levied upon insurers or self-insured
33 employers making reports required by this section.

34 (4) Communications regarding decisions to approve requests
35 by physicians shall specify the specific medical treatment service
36 approved. Responses regarding decisions to modify, delay, or deny
37 medical treatment services requested by physicians shall include
38 a clear and concise explanation of the reasons for the employer's
39 decision, a description of the criteria or guidelines used, and the
40 clinical reasons for the decisions regarding medical necessity. If

1 a utilization review decision to deny or delay a medical service is
2 due to incomplete or insufficient information, the decision shall
3 specify the reason for the decision and specify the information that
4 is needed.

5 (5) If the employer, insurer, or other entity cannot make a
6 decision within the timeframes specified in paragraph (1) or (2)
7 because the employer or other entity is not in receipt of all of the
8 information reasonably necessary and requested, because the
9 employer requires consultation by an expert reviewer, or because
10 the employer has asked that an additional examination or test be
11 performed upon the employee that is reasonable and consistent
12 with good medical practice, the employer shall immediately notify
13 the physician and the employee, in writing, that the employer
14 cannot make a decision within the required timeframe, and specify
15 the information requested but not received, the expert reviewer to
16 be consulted, or the additional examinations or tests required. The
17 employer shall also notify the physician and employee of the
18 anticipated date on which a decision may be rendered. Upon receipt
19 of all information reasonably necessary and requested by the
20 employer, the employer shall approve, modify, or deny the request
21 for authorization within the timeframes specified in paragraph (1)
22 or (2).

23 (6) A utilization review decision to modify, delay, or deny a
24 treatment recommendation shall remain effective for 12 months
25 from the date of the decision without further action by the employer
26 with regard to a further recommendation by the same physician
27 for the same treatment unless the further recommendation is
28 supported by a documented change in the facts material to the
29 basis of the utilization review decision.

30 (7) Utilization review of a treatment recommendation shall not
31 be required while the employer is disputing liability for injury or
32 treatment of the condition for which treatment is recommended
33 pursuant to Section 4062.

34 (8) If utilization review is deferred pursuant to paragraph (7),
35 and it is finally determined that the employer is liable for treatment
36 of the condition for which treatment is recommended, the time for
37 the employer to conduct retrospective utilization review in
38 accordance with paragraph (1) shall begin on the date the
39 determination of the employer's liability becomes final, and the
40 time for the employer to conduct prospective utilization review

1 shall commence from the date of the employer's receipt of a
2 treatment recommendation after the determination of the
3 employer's liability.

4 (h) Each employer, insurer, or other entity subject to this section
5 shall maintain telephone access for physicians to request
6 authorization for health care services.

7 (i) If the administrative director determines that the employer,
8 insurer, or other entity subject to this section has failed to meet
9 any of the timeframes in this section, or has failed to meet any
10 other requirement of this section, the administrative director may
11 assess, by order, administrative penalties for each failure. A
12 proceeding for the issuance of an order assessing administrative
13 penalties shall be subject to appropriate notice to, and an
14 opportunity for a hearing with regard to, the person affected. The
15 administrative penalties shall not be deemed to be an exclusive
16 remedy for the administrative director. These penalties shall be
17 deposited in the Workers' Compensation Administration Revolving
18 Fund.

19 *SEC. 1.5. Section 4610 of the Labor Code is amended to read:*

20 4610. (a) For purposes of this section, "utilization review"
21 means utilization review or utilization management functions that
22 prospectively, retrospectively, or concurrently review and approve,
23 modify, ~~delay~~, or deny, based in whole or in part on medical
24 necessity to cure and relieve, treatment recommendations by
25 physicians, as defined in Section 3209.3, prior to, retrospectively,
26 or concurrent with the provision of medical treatment services
27 pursuant to Section 4600.

28 (b) ~~Every~~ *Each* employer shall establish a utilization review
29 process in compliance with this section, either directly or through
30 its insurer or an entity with which an employer or insurer contracts
31 for these services.

32 (c) Each utilization review process shall be governed by written
33 policies and procedures. These policies and procedures shall ensure
34 that decisions based on the medical necessity to cure and relieve
35 of proposed medical treatment services are consistent with the
36 schedule for medical treatment utilization adopted pursuant to
37 Section 5307.27. These policies and procedures, and a description
38 of the utilization process, shall be filed with the administrative
39 director and shall be disclosed by the employer to employees,
40 physicians, and the public upon request.

1 (d) *Unless otherwise indicated in this section, a physician*
2 *providing treatment under Section 4600 shall send any request for*
3 *authorization for medical treatment, with supporting*
4 *documentation, to the claims administrator for the employer,*
5 *insurer, or other entity according to rules adopted by the*
6 *administrative director.* If an employer, insurer, or other entity
7 subject to this section requests medical information from a
8 physician in order to determine whether to approve, modify, ~~delay,~~
9 or deny requests for authorization, ~~the employer that employer,~~
10 *insurer, or other entity* shall request only the information
11 reasonably necessary to make the determination. The employer,
12 insurer, or other entity shall employ or designate a medical director
13 who holds an unrestricted license to practice medicine in this state
14 issued pursuant to Section 2050 or ~~Section 2450~~ of the Business
15 and Professions Code. The medical director shall ensure that the
16 process by which the employer or other entity reviews and
17 approves, modifies, ~~delays,~~ or denies requests by physicians prior
18 to, retrospectively, or concurrent with the provision of medical
19 treatment services, complies with the requirements of this section.
20 Nothing in this section shall be construed as restricting the existing
21 authority of the Medical Board of California.

22 (e) ~~No~~—A person other than a licensed physician who is
23 competent to evaluate the specific clinical issues involved in the
24 medical treatment services, ~~and where if~~ these services are within
25 the scope of the physician's practice, requested by the ~~physician~~
26 ~~may modify, delay,~~ *physician, shall not modify* or deny requests
27 for authorization of medical treatment for reasons of medical
28 necessity to cure and relieve.

29 (f) The criteria or guidelines used in the utilization review
30 process to determine whether to approve, modify, ~~delay,~~ or deny
31 medical treatment services shall be all of the following:

32 (1) Developed with involvement from actively practicing
33 physicians.

34 (2) Consistent with the schedule for medical treatment utilization
35 adopted pursuant to Section 5307.27.

36 (3) Evaluated at least annually, and updated if necessary.

37 (4) Disclosed to the physician and the employee, if used as the
38 basis of a decision to ~~modify, delay,~~ *modify* or deny services in a
39 specified case under review.

1 (5) Available to the public upon request. An employer shall
2 only be required to disclose the criteria or guidelines for the
3 specific procedures or conditions requested. An employer may
4 charge members of the public reasonable copying and postage
5 expenses related to disclosing criteria or guidelines pursuant to
6 this paragraph. Criteria or guidelines may also be made available
7 through electronic means. ~~No~~ A charge shall *not* be required for
8 an employee whose physician's request for medical treatment
9 services is under review.

10 (g) In determining whether to approve, modify, ~~delay~~, or deny
11 requests by physicians prior to, retrospectively, or concurrent with
12 the provisions of medical treatment services to employees all of
13 the following requirements shall be met:

14 (1) Prospective or concurrent decisions shall be made in a timely
15 fashion that is appropriate for the nature of the employee's
16 condition, not to exceed five working days from the receipt of the
17 information reasonably necessary to make the determination, but
18 in no event more than 14 days from the date of the medical
19 treatment recommendation by the physician. In cases where the
20 review is retrospective, a decision resulting in denial of all or part
21 of the medical treatment service shall be communicated to the
22 individual who received services, or to the individual's designee,
23 within 30 days of receipt of *the* information that is reasonably
24 necessary to make this determination. If payment for a medical
25 treatment service is made within the time prescribed by Section
26 4603.2, a retrospective decision to approve the service need not
27 otherwise be communicated.

28 (2) ~~When~~ *If* the employee's condition is ~~such that~~ *one in which*
29 the employee faces an imminent and serious threat to his or her
30 health, including, but not limited to, the potential loss of life, limb,
31 or other major bodily function, or the normal timeframe for the
32 decisionmaking process, as described in paragraph (1), would be
33 detrimental to the employee's life or health or could jeopardize
34 the employee's ability to regain maximum function, decisions to
35 approve, modify, ~~delay~~, or deny requests by physicians prior to,
36 or concurrent with, the provision of medical treatment services to
37 employees shall be made in a timely fashion that is appropriate
38 for the nature of the employee's condition, but not to exceed 72
39 hours after the receipt of the information reasonably necessary to
40 make the determination.

(3) (A) Decisions to approve, modify, ~~delay~~, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in ~~modification, delay, modification~~ or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. ~~Any~~ A compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in ~~such a way as to minimize~~ *that minimizes* reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. ~~No fees~~ *Fees* shall *not* be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to ~~modify, delay, modify~~

1 or deny medical treatment services requested by physicians shall
2 include a clear and concise explanation of the reasons for the
3 employer's decision, a description of the criteria or guidelines
4 used, and the clinical reasons for the decisions regarding medical
5 necessity. If a utilization review decision to deny ~~or delay~~ a medical
6 service is due to incomplete or insufficient information, the
7 decision shall specify the reason for the decision and specify the
8 information that is needed.

9 (5) If the employer, insurer, or other entity cannot make a
10 decision within the timeframes specified in paragraph (1) or (2)
11 because the employer or other entity is not in receipt of all of the
12 information reasonably necessary and requested, because the
13 employer requires consultation by an expert reviewer, or because
14 the employer has asked that an additional examination or test be
15 performed upon the employee that is reasonable and consistent
16 with good medical practice, the employer shall immediately notify
17 the physician and the employee, in writing, that the employer
18 cannot make a decision within the required timeframe, and specify
19 the information requested but not received, the expert reviewer to
20 be consulted, or the additional examinations or tests required. The
21 employer shall also notify the physician and employee of the
22 anticipated date on which a decision may be rendered. Upon receipt
23 of all information reasonably necessary and requested by the
24 employer, the employer shall approve, modify, or deny the request
25 for authorization within the timeframes specified in paragraph (1)
26 or (2).

27 (6) A utilization review decision to ~~modify, delay, modify~~ or
28 deny a treatment recommendation shall remain effective for 12
29 months from the date of the decision without further action by the
30 employer with regard to ~~any~~ a further recommendation by the
31 same physician for the same treatment unless the further
32 recommendation is supported by a documented change in the facts
33 material to the basis of the utilization review decision.

34 (7) Utilization review of a treatment recommendation shall not
35 be required while the employer is disputing liability for injury or
36 treatment of the condition for which treatment is recommended
37 pursuant to Section 4062.

38 (8) If utilization review is deferred pursuant to paragraph (7),
39 and it is finally determined that the employer is liable for treatment
40 of the condition for which treatment is recommended, the time for

1 the employer to conduct retrospective utilization review in
2 accordance with paragraph (1) shall begin on the date the
3 determination of the employer's liability becomes final, and the
4 time for the employer to conduct prospective utilization review
5 shall commence from the date of the employer's receipt of a
6 treatment recommendation after the determination of the
7 employer's liability.

8 (h) ~~Every~~ Each employer, insurer, or other entity subject to this
9 section shall maintain telephone access for physicians to request
10 authorization for health care services.

11 (i) If the administrative director determines that the employer,
12 insurer, or other entity subject to this section has failed to meet
13 any of the timeframes in this section, or has failed to meet any
14 other requirement of this section, the administrative director may
15 assess, by order, administrative penalties for each failure. A
16 proceeding for the issuance of an order assessing administrative
17 penalties shall be subject to appropriate notice to, and an
18 opportunity for a hearing with regard to, the person affected. The
19 administrative penalties shall not be deemed to be an exclusive
20 remedy for the administrative director. These penalties shall be
21 deposited in the Workers' Compensation Administration Revolving
22 Fund.

23 (j) *This section shall remain in effect only until January 1, 2018,*
24 *and as of that date is repealed, unless a later enacted statute, that*
25 *is enacted before January 1, 2018, deletes or extends that date.*

26 SEC. 2. *Section 1.5 of this bill incorporates amendments to*
27 *Section 4610 of the Labor Code proposed by both this bill and*
28 *Senate Bill 1160. It shall only become operative if (1) both bills*
29 *are enacted and become effective on or before January 1, 2017,*
30 *(2) each bill amends Section 4610 of the Labor Code, and (3) this*
31 *bill is enacted after Senate Bill 1160, in which case Section 1 of*
32 *this bill shall not become operative.*